Nevertheless, it would be irresponsible of me not to point out that abuses still exist. Far too many unnecessary repeated cystoscopies, dilations of urethras, and repair of minimal grades of reflux are being done. Furthermore, some patients are receiving excessive or inadequate chemotherapy. It seems to me that each surgical, diagnostic and therapeutic procedure should be viewed, as are drugs, for both safety and efficacy, using study designs that would be acceptable by the same standard. The papers by the Stanford group clearly point out how this can be done.

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# *Emergency Medicine*

EMERGENCY MEDICINE gives every indication of being a rising star in the firmament of medical practice. Like its immediate predecessor over the horizon—family practice—it is broadly based and draws from among specialties. Both emergency medicine and family practice reflect a swing of the pendulum away from the narrow "vertical" organ system specialties and subspecialties toward a broader more "horizontal" capability to deal with a whole patient. It is worth noting that while family practice focuses on comprehensive and continuing care for a whole patient or a whole family, emergency medicine addresses the whole gamut of patients needing or seeking emergency care, but offers only episodic care in emergent situations where the usual definitive comprehensive or specialty care is not immediately available. This may be in the emergency treatment room of an urban hospital or it may be in a remote place. Both were spawned from general practice.

The advent of emergency medicine has produced much the same sort of critical and negative reactions as did the advent of family practice a few years ago, and for many of the same reasons. In addition there is a certain amount of semantic confusion about the term itself. To some it means the kind of emergencies which occur in a hospital setting and which appropriately are the responsibility of the various specialties in the hospital. To some others it means something like disaster medicine. Yet others consider it to be the immediate care which must be given when medical, surgical or psychiatric emergencies occur in places remote from where definitive care is given. And then there is the kind of care rendered in the emergency rooms or the emergency treatment rooms of hospitals—care for the walk-ins, the drive-ins and the carry-ins. These represent either real emergencies, or equally important, they are emergencies in the minds of those who come seeking help. This episodic, immediate and temporary care, wherever rendered, appears to be the subject matter of the rising specialty of emergency medicine.

This new specialty seems to have a true place in the firmament of modern medicine. There is a need and a demand for quicker and better treatment of medical emergencies, whether these be accidents from the highways, a painful belly or chest, a drug overdose, or a fear in the heart of a father who comes home to find his two-year-old child has a fever and is beginning to wheeze. It is such patients who appear in the treatment rooms of hospitals, large and small. No traditional specialist is trained to care competently for them all —nor is the family physician.

It appears that emergency medicine can and will fill this gap in medical practice.

—MSMW